Premier Health
Premier Physician Network

Breast Care Center Health History Questionnaire

Gem City Surgeons
Miami Valley Hospital North
9000 N. Main St., Ste. 233
Englewood, Ohio 45415
(937) 832-9310
(937) 832-8613 Fax

Atrium Medical Center
Professional Building
200 Medical Center Dr.
Ste. 250
Middletown, Ohio 45005

Today's Date: _____

Appt w/Doctor: _____ Referring Doctor: _____ Family Doctor: _____

Patient Name: _____ DOB: _____ Age: _____

Reason For Appointment: ☐ Breast lump ☐ Breast pain ☐ Nipple Discharge ☐ High Risk Consult

☐ Abnormal Mammogram ☐ Breast Cancer ☐ Routine Check-up ☐ Other: _____

Length of Symptoms: _____

Recent Tests: ☐ Mammogram ☐ Ultrasound ☐ Breast MRI

Location of tests: _____

Past Medical History:

Heart Attack	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
Irregular Heart	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pacemaker/Defibrillator	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
SleepApnea	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Hepatitis .	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No

Cancer(type): _____

Diabetes	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Kidney Failure	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Blood Clot Leg/Lungs	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Connective Tissue Disorders (Lupus,Scleroderma) Dyes	☐ Yes	☐ No

Other: _____

Female Patients - Menstrual History:

Age at onset: _____ Normal Cycle Length(days): _____ Date last period began: _____

Number of Pregnancies: _____ Age of 1st Pregnancy: _____ Number of Live Births: _____

Miscarriages: _____ Abortions: _____ Age at Menopause: _____

Date of Last Pap Smear: _____ Date of Last Mammogram: _____

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Previous Breast Surgery:

☐ Lumpectomy RT LT year_____

☐ Mastectomy RT LT year_____

☐ Implants RT LT year_____

☐ Breast Reduction RT LT year_____

Previous Surgeries (Type, Surgeon, Hospital, Date):

_____

_____

_____

_____

Current Medications & dose (including over the counter.and herbal medications):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies and Type of Reaction:

_____ _____

_____ _____

Social History:

☐ Tobacco Packs per day: _____ Number of Years: _____ When did you quit?: _____

☐ Alcohol Number of drinks per week: _____ ☐ Recreational drugs Type: _____

☐ Caffeine use Amount per day: _____ ☐ Ashkenazi Jewish decent ☐ Yes ☐ No

☐ Profession/job: _____

Family History (has any family member had the following and who?):

Heart Attack: _____ High Blood Pressure: _____

Stroke: _____ Diabetes: _____

Cancer(type?): _____ Other: _____

Review of Systems: (check all that apply)

☐ Chest Pain ☐ Diarrhea ☐ Leg Swelling ☐ Shortness of Breath

☐ Blood in Stool ☐ Night Sweats ☐ Abdominal Pain ☐ Excessive Fatigue

☐ Nausea/Vomiting ☐ Weight Loss ☐ Constipation ☐ Bone Pain

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